METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 1994

8. Private Duty Nursing Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed.

The Medicaid maximum was calculated utilizing an average hourly rate for a registered nurse (RN) of $20.00 and licensed practical nurse (LPN) of $13.50 per hour. The average fringe benefit direct costs are as follows: FICA 7.65% + Workman's Compensation 2.8% + Unemployment Insurance 3.5% + Liability & Bonding 2.05% = 16.0%.

Other averages for indirect costs are as follows: Supervisory Staff & Administrative Staff 15.0% + Rent 1.0% + Recruiting & Training 2.0% + Utilities & Phone 1.0% + Medical & Office Supplies & OSHA Requirements 3.0% + Health Insurance & Vacation 3.0% = 25.0% + Net Profit 3.0% = Total of 28.0%.

The average hourly rate of the RN & LPN was inflated by the average direct costs percentage of 16%.

A gross profit rate of 72% resulted after the average indirect costs (administrative overhead) rate of 28% of the billed rate was applied to the direct salaries plus direct fringes. The average bill rate was calculated by dividing the total of the average hourly rate plus the direct fringes by the 72% gross profit rate.

The above averages were compiled from a 1994 survey of Olsten Kimberly Quality Care, Procare Home Health, and Care Network, Inc. The above calculations result in an hourly rate of $32.22 for the registered nurse and $21.75 for the licensed practical nurse. Through negotiations with the private duty nursing providers, an hourly maximum of $26.73 for a registered nurse and $19.31 for a licensed practical nurse was established.

At the beginning of each calendar year, the State Agency will negotiate with the affected provider group representatives to arrive at a mutually acceptable increase or decrease from the maximum rate. Market forces, such as private insurance rates, medical and general inflation figures, changes in practice costs and changes in program requirements, will be considered during the negotiation process. Any agreed upon increase or decrease will be implemented at the beginning of the following State Fiscal Year, July 1, with any appropriate State Plan changes.

Effective for dates of service on or after October 1, 1994, reimbursement for private duty nursing medical supplies is based on 100% of the Medicare maximum for medical supplies reflected in the 1993 Arkansas Medicare Pricing File not to exceed the Title XIX coverage limitations as specified in Attachment 3.1-A, page 3d, and Attachment 3.1-B, page 4a.

STATE Arkansas	A
DATE REC'D 9-26-94	
DATE APPV'D 10-19-94	
DATE EFF 10-01-94	
HCFA 179 94-23	

SUPERSEDES: TN 94-04

8. Private Duty Nursing Services (Continued)

Refer to Attachment 4.19-B, Item 4.b.(5) for reimbursement information for private duty nursing services for high technology non-ventilator recipients in the Child Health Services (EPSDT) Program.

9. Clinic Services

(1) Developmental Day Treatment Clinic Services (DDTCS)

Reimbursement on basis of amount billed not to exceed the Title XIX maximum. The Title XIX maximum was established based on a 1980 survey conducted by Developmental Disabilities Services (DDS) of 85 Arkansas DDTCS providers of their operational costs excluding their therapy services. An average operational cost was derived for each service. Then an average number of units was derived for each service. The average operational cost for each service was divided by the average units for that particular service to arrive at a maximum rate.

Effective for dates of service on or after September 1, 1999, reimbursement for pre-school services is based on amount billed not to exceed the Title XIX (Medicaid) maximum. The maximum rate represents a 10% increase and was calculated from survey information obtained from 33 Arkansas DDTCS providers who perform this service. Information provided included operational cost and revenue information for the preschool services provided. Per the survey, costs were allocated per revenues.

Occupational, physical and speech therapy services under the DDTCS Program are reimbursed as is described in Item 4.b.(19).

STATE Arkansas
DATE RECD 6-28-99
DATE APPVD 9-17-99
DATE EFF 9-1-99
HCFA ID 99-19

A

SUPERSEDES: TN - ~~99-10~~ 98-22

9. Clinic Services (Continued)

(2) Family Planning Clinic Services

Payment based on reasonable negotiated rate.

(3) Maternity Clinic Services

Payment based on reasonable negotiated rate.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rates were decreased by 20%

(4) Ambulatory Surgical Center Services

Reimbursement rates based on 80% of 1985 HCFA's National payment rates which were inflated by 5% on October 1, 1988.

STATE Arkansas
DATE REC'D 12-1-98
DATE APPV'D 2-13-99
DATE EFF 2-1-99
HCFA 179 98-22

A

SUPERSEDES: TN - 94-24

9. Clinic Services (Continued)

(2) Family Planning Clinic Services

Payment based on reasonable negotiated rate.

(3) Maternity Clinic Services

Payment based on reasonable negotiated rate.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rates were decreased by 20%

(4) Ambulatory Surgical Center Services

Reimbursement rates based on 80% of 1985 HCFA's National payment rates which were inflated by 5% on October 1, 1988.

STATE Arkansas
DATE REC'D DEC 27 1994
DATE APPV'D JAN 19 1995
DATE EFF FEB 01 1995
HCFA 179 94-28

A

SUPERSEDES: TN 94-04

9. Clinic Services (Continued)

(5) End-Stage Renal Disease (ESRD) Facility Services

Reimbursement is made at the lower of : (a) the provider's actual charge for the service or (b) the allowable fee from the State's ESRD fee schedule based on reasonable charge.

The Medicaid maximum is based on the 50th percentile of the Arkansas Medicare facility rates in effect March 1, 1988. Rates will be reviewed annually.

After discussion with HCFA, it was determined that the Arkansas Medicare 75th percentile is considered the norm for Arkansas Medicare reimbursement. Since the State reimburses at Arkansas Medicare's 50th percentile, the reimbursement rates will not exceed Arkansas Medicare on the aggregate.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rates were decreased by 20%.

10. Dental Services

Refer to Attachment 4.19-B, Item 4.b.(18).

STATE
DATE REC'D JUL 20 1992
DATE APPV'D JUN 30 1993
DATE EFF JUL 01 1992
HCFA 179 92-28

A

Supersedes: Attachment 4.19-B, Page 3a, Item 9. (5), approved 1-30-91, TN 90-63, and Attachment 4.19-B, Page 3b, approved 1-24-92, TN 91-60

11. Physical Therapy and Related Services

a. Physical Therapy - Refer to Attachment 4.19-B, Item 4.b.(19).

b. Occupational Therapy - Refer to Attachment 4.19-B, Item 4.b.(19).

c. Speech Pathology - Refer to Attachment 4.19-B, Item 4.b.(19).

1. Augmentative Communication Device Evaluation

Effective for dates of service on or after September 1, 1999, reimbursement for an Augmentative Communication Device Evaluation is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The XIX (Medicaid) maximum is based on the current hourly rate for both disciplines of therapy involved in the evaluation process. The Medicaid maximum for speech therapy is $25.36 per (20 mins.) unit x's 3 units per date of service (DOS) and occupational therapy is $18.22 per (15 mins.) unit x's 4 units per DOS equals a total of $148.96 per hour. Two (2) hours per DOS is allowed. This would provide a maximum reimbursement rate per DOS of $297.92.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed Drugs

The reimbursement rate for prescribed drugs has two components: Drug Ingredient Cost and Dispensing Fee. These components are subject to maximum payment limitations described below.

DISPENSING FEE: The Dispensing Fee is set at $5.51, which represents the survey findings of a statistically valid actual cost of dispensing.

INGREDIENT COST: The ingredient cost is set at Average Wholesale Price (AWP) minus 10.5%.

To assure quality of care and access, the set ingredient costs assures that pharmacies whose dispensing fee and ingredient costs may exceed the statistical survey results are not forced to sustain losses which may cause them to lower quality or terminate their provider contracts.

PAYMENT LIMITATIONS--INGREDIENTS: Arkansas Medicaid identifies certain generically available drugs and places an upper limit of reimbursement on these drugs. These are generic drugs not currently listed on the HCFA Upper Limit List. Acquisition costs on these generically available brands are obtained from multiple sources. The highest acquisition cost plus a percentage is used to set the State Upper Limit. Reimbursement for the ingredient cost of these drugs is limited to the State generic upper limit amount.

The Federal upper limit standard that has been adopted for certain multiple source drugs identified in the State Medicaid Manual, Part 6, is based on an aggregate payment equal to an amount that includes the ingredient cost of the drug calculated according to the formula described below.

The Federal upper limit is an amount that is equal to 150% of the published price for the least costly therapeutic equivalent (using all available national compendia). The aggregate, rather than each individual drug identified by HCFA will be less than or equal to the HCFA defined multiple source cost listed in 42 CFR 447.332.

STATE Arkansas
DATE REC'D 07-07-00
DATE APPV'D 09-06-00
DATE EFF 06-08-00
HCFA 179 00-11

A

SUPERSEDES: TN • 00-05

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

a. Prescribed Drugs (Continued)

Payment for brand name drugs and drugs other than multiple source drugs for which a specific limit has not been established is limited to, in the aggregate, the State established generic upper limit.

PAYMENT LIMITATION-INGREDIENT COST AND DISPENSING FEE: The total charge cannot exceed the provider's actual usual and customary charge to the public.

STATE Arkansas
DATE 3/17/99
DATE APP 4/3/00
DATE EFF 7/1/99
HCFA ID: 99-03

SUPERSEDES: TN - 89-24

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

b. Dentures

Refer to Attachment 4.19-B, Item 4.b. (9).

c. Prosthetic Devices

(1) Eye Prostheses - Refer to Attachment 4.19-B, Item 4.b. (13).

(2) Hearing Aids - Refer to Attachment 4.19-B, Item 4.b. (12).

(3) Ear Molds - Refer to Attachment 4.19-B, Item 4.b. (14).

(4) Pacemakers and Internal Surgical Prostheses - Reimbursed at 80% of invoice price.

STATE Arkansas
DATE REC'D JUL 20 1992
DATE APPV'D JUN 30 1993
DATE EFF JUL 01 1992
HCFA 179 92-28
A

Supersedes: TN 91-29

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: February 1, 1989

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

c. Prosthetic Devices (continued)

(5) Ventilator equipment - Reimbursement is based on the lower of the amount billed or the Title XIX maximum charge allowed.

The Title XIX maximum is based on the following:

(a) The positive pressure ventilator and accessories are based on the LP-6 manufacturer's price (Aequitron Medical - October 1, 1986) for new equipment and 75% of the LP-6 manufacturer's price (Aequitron Medical - October 1, 1986) for used equipment.

(b) The suction pump is based on Medicare's rate in effect in August 1987 for new equipment. Used equipment is based on 75% of Medicare's rate.

(c) The negative pressure ventilator and accessories are based on the manufacturer's price plus 10% for the maintenance, delivery, set up, emergency call, 24/hr/day, 7 day/week availability.

(d) The oxygen concentrator, liquid oxygen, liquid oxygen walker and reservoir, hospital bed and nebulizer are based on the DME Fiscal Year 1981 Medicare median.

(e) The ventilator supplies are based on the manufacturer's price.

The reimbursement methodology includes a provision for automatic adjustments based on fluctuations in the economy.

STATE AR
DATE REC'D MAR 3 1989
DATE APP'D MAR 29 1989
DATE EFF FEB 1 1989
HCFA 179 89-08

A

Supersedes 88-05